



State of New Jersey • Department of the Treasury

DIVISION OF PENSIONS & BENEFITS

P.O. Box 295, Trenton, NJ 08625-0295

MEMBER AUTHORIZATION FORM

FOR USE AND DISCLOSURE OF PROTECTED AND PRIVATE INFORMATION

PART 1 — MEMBER'S INFORMATION

Member's Name		First	MI
Address	City	State	e Zip
Phone Number	Email		
Member's Social Security Nu	mber	Date of Birth _	
& Benefits (NJDPB) to releat that health information from	below and signing this form, I ase and/or disclose my protecte the NJDPB can be provided to r of the Administrative Simplificat A) of 1996.	d and private information ne, but is otherwise Prote	n. Further, I understand ected Health Information
I submit this form voluntarily described below.	to document my wishes regard	ling the use and/or disclo	sure of the information
The following is a specific de	scription of the information I auth	orize be used and/or discl	osed:
I authorize my protected and	private information to be used ar	nd/or disclosed for the follo	owing specific purposes:
	son(s) or organizations to receiv the purposes listed above. I und al privacy standards.		

Expiration of Authorization. Upon release of the information described above, this authorization request will expire. Any future requests to release and/or disclose protected and private information will require a new *Member Authorization Form*.

MEMBER'S SIGNATURE

I have had an opportunity to review and understand the contents of this form. I have signed this form voluntarily and confirm that it accurately reflects my wishes regarding the use and/or disclosure of this information. I understand that the requested documents will be mailed via the United States Postal Service (USPS) First-Class mail and will not require a signature.

			/ /
Λ	Member's Signature		Date
If signed by a personal representati	ve, complete the following:		
Name of personal representative _			
Relationship to member or nature of	f authority		
(e.g., health care power of attorney, guardia	nn, other legal authorization — A copy of o	documentation must be attac	ched.)
Address			
Street	City	State	Zip
			1 1
Signature of Personal Representative			// Date
Phone Number		Email	
Return completed form to:	New Jersey Division of Pens Office of Client Services	sions & Benefits	
	P.O. Box 295		

Trenton, NJ 08625-0295